

California community, the physician community has expanded from eight family physicians and a part-time radiologist to nine family physicians, two general internists, two general, thoracic and vascular surgeons, two orthopedic surgeons, one anesthesiologist, a full-time radiologist, an ENT specialist, a urologist, a podiatrist and a nurse anesthetist. This expansion of personnel has been accompanied by a change in the medical and surgical case mix, and in the average "level of performance" in the patient care. Some of the older physicians, who were previously quite active in surgery, medicine and obstetrics, have started to refer patients to specialists for care in these areas. As a matter of pride, however, they are reluctant to relinquish hospital privileges for areas in which they choose to refer but in which they nonetheless continue to feel competent. The specialists are concerned, in their turn, about the increasing incompetence of the physicians whose current experience is scant. The younger family physicians view with alarm any move to restrict the privileges of similarly trained physicians in areas where the younger physicians are actively practicing.

Our staff has a sincere commitment to quality of care and a commitment to work together to find solutions to staff governance problems. Long discussions between the advocates of privilege restriction and the advocates of privilege maintenance has resulted in a three stage compromise solution:

- *Stage A.* For a physician who has not done a particular procedure or one of similar and related type for two years (we are on a two-year surveillance schedule), all charts related to such care will be reviewed by a member of the surgery committee to check for complications.

- *Stage B.* If the procedure (or related one) has not been performed for four years, another physician must be present to observe and evaluate the surgeon and report on adequacy of performance to the surgery committee.

- *Stage C.* If the procedure has not been done for six years, a physician with unrestricted (or stage A) privileges must be chosen (or assigned by the chief of surgery) to evaluate surgical performance and report to the surgery committee. The surgery committee has agreed that no one will be granted surgical privileges without agreement to fulfill this evaluator role.

This system is a compromise. No one is satisfied, but everyone can live with it. The surgeon specialists believe that infrequent surgeons should be denied privileges, but they are willing to accept close evaluation of performance as an alternative. The older generalists, who are the infrequent surgeons, do not believe that such supervision is necessary or proper, but since privileges are not being denied, they are reassured. The younger generalists are reassured that they will be evaluated based on skill and competence, not board eligibility.

Not only are we hopeful that this system should work for assuring patients of competent handling by

the generalists, but it should function just as impartially in the case of a surgical specialist who may be an infrequent surgeon in one or more areas of his field.

ROGER K. HOWE, MD  
Mt Shasta, California

## A Good Doctor

TO THE EDITOR:

*Faces we see, hearts we know not.* Spanish proverb

Since my graduation from medical school almost 25 years ago, I have interviewed numerous young people who either aspire to become doctors or, having already done so, are competing for a training position or practice opportunity. Experience has taught me the frustrations and occasional mistakes involved in the attempt to measure a "good doctor."

Letters of recommendation and the curriculum vitae are helpful, but far from perfect. I look for signs of high intelligence and excellent health. I search for traits of integrity, discipline, diligence, curiosity, caring and especially personal honor.

The interview begins and ends. I have talked, listened and observed. I now know the applicant, but do I know his or her heart?

RICHARD R. BABB, MD  
Palo Alto, California

## Treatment for Rhus Dermatitis

TO THE EDITOR: Many readers may be interested to learn of a treatment for the itch of poison oak (rhus) dermatitis that is inexpensive, not unpleasant, safe and apparently more effective than much conventional therapy. The use of hot soapless showers for this disorder is not mentioned in standard textbooks of allergy or dermatology. After our interest in this technique developed, however, a letter of inquiry was sent to 100 local physicians. Eight of them had found it to be helpful in treating their own rhus dermatitis and three of them had repeatedly recommended it to patients because of its apparent effectiveness. Most primary physicians and dermatologists, however, were unaware of its use.

During previous episodes of rhus dermatitis extending over a 40-year period, I had confirmed many times the marginal relief obtained with topical corticosteroids<sup>1</sup> and had found the side effects that accompanied systemic steroids to be unacceptable to me. It was with great delight, therefore, that a hot shower was found to be followed by several hours completely free of pruitus, and that frequent subsequent showers were each equally effective. After this personal discovery, shower therapy was undertaken seven times during the first 24 hours and less frequently, but as often as required, thereafter. The uncomfortable days and restless nights that had characterized earlier episodes of dermatitis were replaced by predictably undisturbed between-shower intervals during which I was able to feel well and function normally.

Since then, 15 patients with recurrent poison oak

dermatitis have been asked to compare the effectiveness of hot showers with that of 0.1% triamcinolone cream, used as freely and frequently as desired. Some of these patients were also treated with systemic corticosteroids. Showers were taken without soap, by directing "comfortably hot" water onto affected areas until the resulting pleasant sensation had subsided, and any accumulated exudate had been washed away. Each affected area was then patted dry with a towel. All patients reported that hot showers resulted in hours of complete or nearly complete relief from their itch, whereas the topical steroid was of little or no help in this regard. Several patients required reassurance that their therapy could not spread their disease, the appearance of new areas of dermatitis representing the natural history of their disorder.

In none of the patients using the hot shower treatment did secondary infection develop, a frequent complication of conventional therapy. This apparent advantage seemed likely to have resulted from the cleansing action of hot water, the washing away of the exudate which otherwise provided a rich culture medium for bacterial growth and the effective prevention of scratching and rubbing with their attendant trauma and bacterial contamination.

Our experience suggests that this technique is worthy of much more widespread use.

HARRY W. DANIELL, MD  
Redding, California

## REFERENCE

1. Kaidbey KH, Kligman AM: Assay of topical corticosteroids—Efficacy of suppression of experimental *Rhus* dermatitis in humans. *Arch Dermatol* 1976 Jun; 112:808-813

## Ectatic Is Not Tortuous

TO THE EDITOR: I read with interest the Medical Progress article "Abdominal Aortic Aneurysms."<sup>1</sup>

I would like to comment on the improper usage of the word "ectatic" as a synonym for "tortuous" or "uncoiled."

*Dorland's Illustrated Medical Dictionary* defines ectatic as "distended or stretched." This definition applies to the aorta, as well as to the bronchi (bronchiectasis), ureter (ureterectasis), mammary duct (mammary duct ectasia) and so forth.

Descriptions of a normal-caliber aorta as "ectatic," when one really means "tortuous" or "uncoiled" can only lead to confusion.

MELVIN S. ROSEN, MD  
Associate Professor of Radiology  
Mount Zion Hospital and  
Medical Center  
San Francisco

## REFERENCE

1. Fortner G, Johansen K: Abdominal aortic aneurysms (Medical Progress). *West J Med* 1984 Jan; 140:50-59

## Outlawing Boxing

TO THE EDITOR: Dr Joseph Elia's statement in "Physicians and Boxing"<sup>1</sup> that if boxing is banned it will go underground will not hold. Boxing flourishes because of the huge pots made available by TV revenues, sta-

dium attendance and the like. Once these are gone so is the financial lure for athletes.

Boxing is legalized brutality. Attempts to sanitize it will fail. The public (no different from the mobs at a Roman coliseum) pays to see the gory battering and knockdown. Anything less is boring and the TV ratings fall. The great majority of youths who are lured into this "sport" by the promise of gold and glamour wind up as brain-damaged wrecks, if not fatalities. Physicians should exert every effort to get this barbarism outlawed. Sweden and Norway have done so<sup>2</sup> and we should follow their lead.

HERSCHEL S. ZACKHEIM, MD  
Redwood City, California

## REFERENCES

1. Elia JC: Physicians and boxing (Correspondence). *West J Med* 1983 Nov; 139:717
2. Timberly WR: Banning Boxing. *Brit Med J* 1982 Jul 24; 285(6337): 289

## Do-Not-Resuscitate Orders and the Doctor-Patient Relationship

TO THE EDITOR: As a fourth-year medical student who will soon be facing questions of life and death concerning my own patients, I was very dismayed to read the hospital reports on do-not-resuscitate (DNR) orders in the January issue.<sup>1,2</sup>

Unfortunately, I was not surprised.

The articles indicated that house officers are most responsible for no-code orders; indeed, the Portland VA study<sup>2</sup> revealed that interns and residents participated in DNR decisions much more than attending physicians, family members or the patients themselves did.

My own experience has been similar. Decisions to not resuscitate patients whom I have followed have invariably been reached by an intern or resident after a brief discussion with the patient or patient's family. Often, the actual question of "resuscitation" was never raised; instead, the participants would vaguely discuss the patient's prognosis and how he or she might like to die. Rarely was the discussion prolonged or debated. Even more rarely did the attending physician participate. Never was a priest or minister or lawyer or any other kind of counselor involved.

On the positive side, I think that in all the cases there was good reason not to resuscitate—the patient having either an obviously terminal illness or a very long history of hospital care—but I found the decision process perfunctory and demeaning. I certainly do not want to be treated that way when I or one of my parents is old and sick.

Physicians are not philosophers or clerics; yet we are very often in a position to act that way. And while it is not reasonable to assume that we should all be-

Items submitted for the Correspondence section should be typed double-spaced (including references) with conventional margins. The text should not exceed 600 words.